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Pfizer *Listening to pharmacy*

a healthy partnership™

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> THE HEALTH SECRETARY SAID HE WAS KEEN FOR PHARMACISTS TO PLAY A GREATER ROLE AND DESCRIBED THE SECTOR AS HUGELY COMPETENT AND HUGELY UNDERUSED

There's a GP in the office who sits about five desks away and, despite the promise of £80 billion coming his way, he's not a happy bunny.

I suspect the enormity of the task foisted upon his shoulders by the health secretary Andrew Lansley in this week's health white paper has just hit home. Along with his 36,000 GP colleagues, he will be charged with taking responsibility for delivering cost-effective, clinically sound NHS services across England.

Aside from shifting commissioning responsibility to the proposed GP consortia, Mr Lansley has ruthlessly swept away PCTs and strategic health authorities, as he looks to cut billions from the NHS budget – a move that will be cheered by pharmacists. While PCTs were a good idea, their general inability to engage wholeheartedly with the country's biggest network of health providers has been shameful.

Furthermore, a new NHS commissioning board will take over responsibility for England's pharmacy services. This will, through "payment for performance", incentivise high quality and efficient services. And pharmacists have an "important and expanding role" and will benefit from "greater transparency in NHS pricing and payment for services", we are promised. It all sounds great – a rosy future for the sector. But it wouldn't be the first time ministers have promised to tackle the sector's woes.

And this week's NHS blueprint is again high on vision and low on detail, leaving pharmacists with a plethora of unanswered questions. With PCTs being scrapped, what happens to the global sum and pharmaceutical needs assessments? If the NHS commissioning board is not going live until 2012, what does this mean for the pharmacy contract – are negotiations on hold for two years and will the cost of service inquiry data be out of date? And just what role will pharmacy play in supporting the new GP consortia to deliver their objectives?

A chance comment in C+D's sister title Practical Commissioning does, however, offer a useful insight. Its regular diarist, Peter Weaving, a GP and locality lead in Cumbria, describes a meeting he had with Mr Lansley just a few days prior to the health white paper's publication. Asked about pharmacy, the health secretary told him he was keen for pharmacists to play a far greater role in managing people's health and described the sector as hugely competent and hugely underused. Interestingly, Dr Weaving says Mr Lansley believed pharmacy's national contract was ridiculous and should be determined locally.

Quite how locally determined contracts will fit with a sector that is dominated by national chains is unclear. It looks as if PSNC will face some difficult discussions both with its members and the new NHS Commissioning Board. But if the potential rewards mean community pharmacy finally has the platform to demonstrate just what it is capable of, the pain of another contract upheaval could be bearable.

Gary Paragpuri, Editor

Cover: Getty Images

PCTs scrapped under Lansley's radical health white paper

Pharmacy to be commissioned by new board

Hannah Flynn
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PCTs will be scrapped under plans outlined in the health white paper, presented to Parliament by the health secretary, this week.

Andrew Lansley outlined plans on Monday to transfer commissioning roles to GPs, a new NHS commissioning board and local authorities from next year.

Pharmacy services will be the responsibility of the NHS Commissioning Board. But GP consortia will have influence and involvement in decisions, the paper added.

The 61-page health white paper makes four explicit references to pharmacy. These include a commitment to incentivise the sector through payment for performance under a new contract.

The sector will also benefit from plans to make NHS payments and services more transparent, the government stressed.

However, immediate reaction to the white paper was dominated by concerns over GP consortia.

Ash Soni, contractor at Copes Pharmacy, London, and PEC chairman, demanded safeguards to stop GPs monopolising funds on BBC's Newsnight this week.

"If you make [commissioning] transparent and involving patient choice, pharmacy is in a strong position. But you need these safeguards built in," he told C+D.

Mr Lansley, who also appeared on the programme, stressed that GP consortia would involve other NHS clinicians.

He said: "It will be general practice-led commissioning, not general practitioner-led commissioning... the delivery of primary care depends on a multidisciplinary team."

Over 500 GP consortia could take on funds from 2013 under plans. The model will be in place in shadow form from 2011.

Public health service funding will rest with local authorities under proposals. Authorities will be guided by "health and wellbeing boards" charged with joining up the commissioning of NHS service, social care and health improvement.

The move was a positive one for pharmacy, said Sue Sharpe, PSNC chief executive. "Pharmacies are well placed to build links with local councils and are ideally placed to help them."

Mrs Sharpe also backed the white paper's reforms around primary care commissioning. She added: "The development of community pharmacy services has for too long been held back by the vagaries of patchy PCT commissioning, and this process of reform represents an opportunity to find a better, more cohesive way of ensuring all communities can benefit from high quality pharmacy services."

Lansley's key reforms

- PCTs abolished by 2013
- New NHS commissioning board to be responsible for pharmacy services
- GP consortia to direct local NHS commissioning groups will be open to pharmacists
- New pharmacy contract to be built on payment by performance
- Greater transparency in NHS pricing and payment for services

Patients to decide providers

Patients will have a greater say over who provides their healthcare and what treatment they are given within four years, the government has announced.

The plans, part of a drive to increase patient choice under the mantra "no decision about me without me", were set out in the health white paper.

Under the white paper plans, patients will be offered the choice of "any willing provider" to deliver health services. Other key aspects include patient control over who has access to health records and a rollout of personal health budgets. Choices over diagnostic testing will be introduced from next year, with choice over some mental health services from April.

"We expect choice of treatment and provider to become the reality of patients in the vast majority of NHS-funded service by 2013-14," the white paper states.

Writing to health secretary Andrew Lansley, NPA chair Ian Facer welcomed the move to place patient choice at the heart of health agenda.

He said: "The voice of patients should be paramount. This is right in principle and practice, and can only be good news for pharmacists because of the bond of trust that already exists between us and our patients."

To ensure all patients have a voice, the government will create an independent consumer champion, Health Watch England, to ensure patients are able to feed back about local services and commissioning.

However, the proposals were welcomed cautiously by The Patients Association director Katherine Murphy, who warned the redesign of the NHS structure could cause instability, and there was "a long way to go". **CC**

PSNC chief takes the positives from the paper
www.chemistanddruggist.co.uk/healthwhitepaper

White paper timeline

Commissioning reforms:

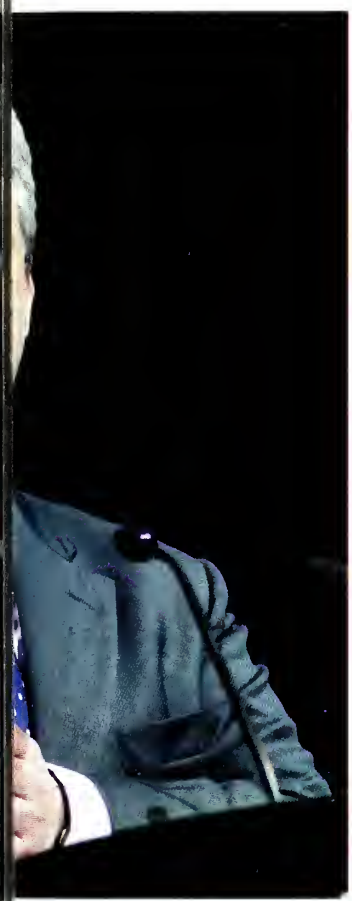
- Publish white paper on public health plans 2010
- Launch NHS Commissioning Board in shadow form April 2011
- Launch GP consortia in shadow form April 2011
- Scrap PCTs 2013
- GP consortia to take on full commissioning powers April 2013

Pay:

- Announce principles behind new financial allocation process April 2011
- Extend payment by results to community services April 2012
- Ring-fenced public health budgets allocated in shadow form April 2012

Pharmacy pay to reward quality

Performance linked to pay in new contract



Zoe Smeaton
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Community pharmacists must prepare for a new contract that will reward quality of service delivery rather than dispensing volume, industry leaders have warned.

The comments came as the government's white paper said the sector would be paid for performance in the future and would benefit from "greater transparency in NHS pricing and payment for services".

The changes would come alongside a shift towards value-based pricing for medicines, the paper said.

"The community pharmacy contract, through payment for performance, will incentivise and support high quality and efficient services, including better value in the use of medicines through better informed and more involved patients," the document stressed.

Faisal Tuddy, commercial manager on the pharmacy team at Asda, said: "To achieve the government's stated outcomes we will need a new pharmacy contract that puts the needs of patients first. Anything less will just be tinkering around the edges."

Asda added that the changes would be challenging for some pharmacists as remuneration moved from dispensing to other services. Mark James, managing director at AAH, warned that any future funding based on performance needed to fairly reward the sector. And Avicenna CEO Salim Jetha said payment on outcomes "must not be riddled with excessive administration burden".

Jonathan Mason, the Department of Health's community pharmacy tsar, said: "Pharmacy remuneration may well need to change if [the government] is going to incentivise pharmacists as medicines optimisers."

But the sector could benefit from greater transparency in payments, the NPA said, as community pharmacy-based services were "among the most cost-efficient". It is hoped the transparency may help to end the variable pricing for pharmacy services, as shown by C+D's PCT Investigation last year.

EXCLUSIVE Comment | **Pharmacy minister's verdict on the white paper**

Every day, millions of people visit their community pharmacy for advice and treatment.

Community pharmacies are ideally placed to conveniently deliver a wide range of health services close to people's homes.

We have just published our white paper – Equity and Excellence: Liberating the NHS. It presents pharmacies with a tremendous opportunity for working more closely with the public, patients, doctors and other health professionals, to support better health outcomes.

I want community pharmacists to expand the range of clinical and public health services they deliver. I want them to help patients get the most from their medicines, to better manage their conditions, to focus on prevention as well as treatment, and to help patients be better informed and more involved with their care. Community pharmacies can help to reduce health inequalities and

prevent people from getting ill by helping them to change the way they live their lives.

Pharmacy services will benefit from greater transparency in NHS pricing and payment for services. Through payment for performance, those who deliver high quality patient care and NHS services that are safe and clinically effective will be rewarded.

The NHS Commissioning Board will be responsible for commissioning a range of family health services, including community pharmacy. We will look at what further changes we need to make to provide better, more patient-centred healthcare.

Many community pharmacies already do excellent work to improve the public's health. As the public health service emerges, I want to see far more pharmacies following their example, working with their local authority and director of public health.

I am looking forward to working with you all to ensure that community pharmacy plays a vital role in delivering the government's priorities for the National Health Service.

Earl Howe, pharmacy minister

More views at **www.chemistand druggist.co.uk/healthwhitepaper**

Your white paper verdicts

"We now need to see much greater clarity and detail. I hope ministers and officials recognise funding not only needs to be performance-related and transparent, it also needs to fairly reward the professional contribution of pharmacists and be sufficient to sustain the community pharmacy network."
Mark James, AAH MD

"I think overall this is positive for pharmacy, although I know some pharmacists might not think that. There is a very positive line [about pharmacists having an important role in optimising the use of medicines and supporting better health] and we can badge a lot of what we do on the back of that."
Jonathan Mason, DH community pharmacy tsar

"Pharmacy does get a mention, but how exactly it will fit into the structure is not very clear at all. We may feel we have been getting somewhere with our PCTs regarding commissioning of services, but if they are then scrapped it is back to square one."
Gordon Couper, Handbridge Pharmacy, Chester

"It takes me back to the days when local surgeries could hold funding and control quite a bit of money. If it is like that then I have been there and I survived it."
John Throup, Burrows & Close Pharmacy, Calverton

Get more health white paper verdicts online
www.chemistanddruggist.co.uk/healthwhitepaper

In brief

Boots video interviews

Alliance Healthcare executives highlighted their continued commitment to services and partnerships at the opening of its Exeter service centre on Monday July 12. Watch C+D's video interviews with Alliance Boots executive chairman Stefano Pessina, group chief executive Andy Hornby and pharmaceutical wholesale division head Ornella Barra from the event last week.
www.chemistanddruggist.co.uk

Clinical study days

Pharmacists are invited to attend two UK Clinical Pharmacy Association study days on allergy and asthma, and cardiology. The allergy and asthma event takes place at the Leicester Ramada on October 7, while the cardiology day is on September 17 at The Studio, Birmingham.
www.ukcpa.org

Teva recall

Teva UK has recalled all remaining stock of three batches of glibenclamide tablets that may not meet the specifications for tablet dissolution 12 months from manufacture. The batches are glibenclamide 5mg tablets in Teva UK livery batch 000537, expiry September 2012, 1x28, and batch 001315, expiry September 2012, 1x28; and in Generics (UK) livery batch 000681, expiry September 2012, 1x28.

Weight loss clubs best

Two studies of a selection of popular slimming supplements have found no evidence they help patients lose weight beyond the placebo effect, the International Congress on Obesity has heard. But a third study revealed structured programmes to aid weight loss can be effective.

Phoenix funding

The parent company of Phoenix Medical Supplies has secured finance for its long-term future in Europe, the group has announced. Phoenix UK CEO Paul Smith said he expected the new financial structure to enable the wholesaler to consolidate its existing position and continue growth in the UK pharmaceutical market.

NI pharmacy gets £28m Cat M compensation

Settlement will relieve "immense financial hardship", says PCC

Hannah Flynn
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Pharmacists in Northern Ireland (NI) will receive £28 million in compensation for outstanding money owed to them from illegal category M reductions.

The money will be sent to individual contractors following an agreement between the Pharmaceutical Contractors Committee NI (PCC) and the Department of Health, Social Services and Public Safety (DHSSPS).

The settlement follows a judicial review ruling in PCC's favour earlier this year, which decided NI pharmacies were entitled to receive payment for outstanding category M monies for the period 2007-10.

Loretta McManus, of Erne Pharmacy, Enniskillen said she was pleased the settlement has been reached as the talks were long and drawn out.

Ms McManus said: "For many contractors category M was a breadline matter. I know contractors who couldn't take on a second pharmacist because of category M, and even had to worry about the impact this would have on their ability to take out loans. It has been a very serious matter."

In a letter to contractors in NI, PCC chief executive Gerard Green said: "PCC is acutely aware of the immense financial hardship endured by contractors as a result of category M over recent years which, in turn, is being compounded by the current difficult economic and financial climate."

Mr Green went on to say interim arrangements have been made for the financial year 2010-11, when additional funding will be made available to contractors in respect to category M. The letter also outlined plans for new contract discussions.

He added: "Furthermore PCC and DHSSPS have agreed to recommence new contract discussions and negotiations immediately, so that new arrangements, including a new NI Drug Tariff, are in place post-March 2011."

Mr Green said he hopes the settlement goes some way to reinstating an element of financial stability for contractors.

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

Better clinical outcomes ahead?

In the whirlwind of change sweeping through the NHS in the wake of Andrew Lansley's white paper, it's easy to forget its focus is on improving patient care. The essential question has to be whether the paper bodes well for the nation's health – and that comes down to the nitty gritty.

The problem is that every clinical win is held back by a caveat, mostly due to the white paper's (necessarily) top-line view. Take pharmacy services, which will be commissioned from a centralised body. This could end the current patchy commissioning, and allow pharmacists to work in different areas without having to prove their clinical skills repeatedly.

But with the current lack of detail on just how this commissioning board will work, it's hard to tell how services will develop.

The suggestion of a performance-based framework also raises key clinical questions. While rewarding those who deliver quality outcomes ties in with the 2008 pharmacy white paper, some argue GP-style QOFs haven't always been drafted in a way that drives patient outcomes. Last year National Obesity Forum chair David Haslam criticised the system, stating with the QOF he was "incentivised to identify fat people and make a list of them, and with the list do absolutely nothing". You might say the proof of the pudding for pharmacy will be in the eating.

Self-care is a potential winner, too. According to the Self Care campaign, up to £2 billion could be saved by encouraging patients to self-treat rather than present to a GP. A pharmacy-based minor ailments service would seem a logical step – but there's no mention of a national rollout in the government's plans.

The only definite winner in the future is evidence-based medicine. After a quick probing from MP David Tredinnick on whether homeopathy would be more widely available, Mr Lansley said commissioning would be based solely on "scientific evidence, clinical evidence and guidelines". Isn't that about as close to 'no' as you can get without saying it?

Only time will tell if the white paper truly serves up The Greatest Healthcare Revolution Since The Founding Of The NHS (™). For the moment, although the rumbles from Whitehall are positive, it's too early to say what the proposals will mean for frontline clinical care.

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

AN ANNOUNCEMENT FROM ALLEN & HANBURYS

In January 2009 Allen & Hanburys launched Avamys®▼ (fluticasone furoate), an intra-nasal steroid (INS) for treatment of the symptoms of allergic rhinitis.[1] Avamys (fluticasone furoate) is a different chemical entity to Flixonase® (fluticasone propionate) and is therefore a distinct drug molecule and not a salt or a prodrug of fluticasone propionate.[2]

A survey taken in May 2009, amongst 128 pharmacists showed that:[3]

- 31% were unaware of this INS (Avamys, fluticasone furoate).
- 63% were not aware of the differences between fluticasone furoate and fluticasone propionate.

Allen & Hanburys would like to highlight the important key differences that will support you in dispensing the right medicine.

	fluticasone furoate[1,4]	fluticasone propionate[4,5]
Dose per spray	27.5mcg	50mcg
Sprays per pack	120	150
Licence Age	6 years and older	4 years and older
Cost (on prescription)	£6.44	£11.01

In a single dose study comparing Avamys to fluticasone propionate nasal spray, patients preferred Avamys over fluticasone propionate based on sensory attributes.[6] Avamys provides relief from both nasal and ocular symptoms in an advanced device.[7-10] Avamys is available to purchase from AAH and Alliance Healthcare.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys®▼ Nasal Spray Suspension
(fluticasone furoate 27.5 micrograms/metered spray)
Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). Reduce to lowest dose at which effective control of symptoms is maintained. *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active substance or excipients. **Side Effects:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). *Common:* nasal ulceration. *Rare:* hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria. **Precautions:** Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Consider referring to a paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma and/or cataracts. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the foetus or child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Marketing Authorisation Number:** EU/1/07/434/003. **Legal category:** POM. **PL holder:** Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

Avamys is a registered trademark of the GlaxoSmithKline group of companies.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing.)

Flixonase® Aqueous Nasal Spray
(fluticasone propionate 50 micrograms/metered spray)
Uses: Prophylaxis and treatment of seasonal allergic and perennial rhinitis in adults and children aged 4 years and over. **Dosage and administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily in the morning. Once symptoms controlled, use maintenance dose of one spray per nostril once daily. Two sprays per nostril twice daily may be required. Maximum daily dose four sprays per nostril. *Children aged 4 to 11 years:* One spray per nostril once daily in the morning. One spray per nostril twice daily may be required. Maximum daily dose two sprays per nostril. For full therapeutic benefit regular usage is essential. The minimum dose should be used at which effective control of symptoms is maintained. **Contra-indication:** Hypersensitivity to any of its ingredients. **Precautions:** Local infections should be appropriately treated. Caution when transferring patients from systemic steroids. Systemic effects of nasal corticosteroids may occur at high doses for prolonged periods. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. In addition, consider referring patients to a paediatric specialist. Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Avoid concomitant administration of inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole, and ritonavir. **Pregnancy and lactation:** Clinical data is not available. Balance risks against benefits. **Side effects:** Very common: Epistaxis. Common: Headache, unpleasant taste, unpleasant smell, nasal dryness, nasal irritation, throat dryness, throat irritation. Very rare: Cutaneous hypersensitivity reactions, angioedema, bronchospasm, anaphylactic reactions, glaucoma, raised intraocular pressure, cataract, nasal septal perforation. **Presentation and Basic NHS cost:** *Flixonase Aqueous Nasal Spray:* 150 metered sprays - £11.01. **Market Authorisation Number:** PL 10949/0036. **Market Authorisation Holder:** Glaxo Wellcome UK Limited trading as Allen & Hanburys, Stockley Park West, Middlesex, UB11 1BT. **Legal category:** POM. **Date of preparation:** January 2010.

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Flixonase is a registered trademark of the GlaxoSmithKline group of companies.

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GlaxoSmithKline

For more information on Avamys visit **www.eyesandnoses.co.uk**

Date of Preparation: May 2010 UK/FF/0070/10

ALLEN & HANBURYS

Dispensary talk

Did you take any time off work to watch the World Cup?

"No, I didn't take any time off work as I am not interested, and none of my staff took any time off either."
Kaushik Patel, Jaywick Pharmacy, Clacton-on-Sea, Essex

"I am sure people did watch the World Cup but no one took any time off. I just don't think people were that interested."
Ceri Evans, Rowlands Pharmacy, Kettlethorpe, Wakefield

Web verdict

No – I am not fussed about football 77%

Yes – I took up my employer's offer of flexible working to watch some games 2%

Yes – I took holiday so I didn't miss some matches 22%

Armchair view: Over three quarters of pharmacists were not fussed about the World Cup, however one in five booked time off work so they would not miss key games. Despite some employers offering flexible working during the tournament, only 2 per cent took it up.

Next week's question:
Will the white paper be good or bad for community pharmacy? Vote at **www.chemistanddruggist.co.uk**

Dispense clopidogrel off licence, PCTs advise

East Yorkshire pharmacists told to change policy to save cash

Chris Chapman
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Yorkshire PCTs have told pharmacists it is acceptable to dispense generically prescribed clopidogrel after Lloydspharmacy instructed pharmacists to query prescriptions potentially using the drug off licence.

Lloydspharmacy had told pharmacists to question all prescriptions for clopidogrel in combination with low-dose aspirin and return for amendment unless the brand Plavix or the generic hydrogen sulphate salt was specified.

Although generic clopidogrel is licensed for all applications in the EU, in the UK a patent prevents generic clopidogrel hydrochloride or besilate being licensed for the prevention of atherothrombotic events in patients with acute coronary syndrome.

However, medicines management teams from NHS Hull and NHS East Riding of Yorkshire wrote to all pharmacists in East Yorkshire, advising them to end the policy. The generics' balance of efficacy and safety made it "reasonable" to use the products off label, the PCTs countered.

"It is likely that the cost of generic clopidogrel will become significantly lower than the branded product over the next few months and the potential savings on the drugs bill for both pharmacy and secondary care will be significant," the PCT letter added.

Lloydspharmacy superintendent Steve Howard said the multiple had acted in line with RPSGB guidance to ensure prescribers were aware the medicine was being used off licence, and seek approval so the right product could be supplied.

"Many primary care organisations have stated that it is acceptable to supply [clopidogrel] against all prescriptions and where we have been informed this is the case the information has been passed to pharmacies," Mr Howard said.

First community automated dispensing machine ready to go

The first automated dispensing machine in a UK community pharmacy is ready to go live once laws are clarified, C+D can reveal.

The machine, which is installed in Primary Care Pharmacy Nuneaton, is fully operational but not in use due to questions over supervision laws, which require a responsible pharmacist to be in charge of every pharmacy.

The machine, installed by robot companies ARX and Rowa, would allow pharmacists to dispense prescriptions out of hours.

Customers are given a pin code to access the pharmacy's foyer, where they are able to speak to a pharmacist via a video link. The pharmacist can then dispense the medicine via the pharmacy's robot.

The automated dispensing machine at Primary Care Pharmacy, Nuneaton

ARX spokesman Luke Lowles-Hourigan said the company was "close" to piloting the new system. "It's functional... but it's still a grey area for the law," he added.

Michael Burr, of Primary Care Pharmacy, said the pharmacy was also considering using the automated dispensing machine to dispense repeat prescriptions.

Last month PharmaTrust announced its intention to pilot automated dispensing machines in hospital pharmacies, rolling out to community premises by late 2011. **CC**

Prepared for the health problems of returning World Cup travellers?
See our 10-point guide on p15

MHRA licenses Botox to treat chronic migraine

Botox can now be used as a preventative treatment for headaches in chronic migraine, following approval from the MHRA.

The botulinum toxin injection, which is usually associated with cosmetic surgery, received the licence extension after being shown to reduce the frequency of episodes in patients who experience headaches on at least 15 days per month, of which at least eight days are with migraine.

The news follows the results of the PREEMPT trial, which found patients receiving 31 Botox injections into seven specific head and neck muscles, with an additional eight injections to relieve specific pain, experienced significantly fewer days with headache than those treated with placebo.

Botox is also currently licensed fo blepharospasm, hemifacial spasm, cervical dystonia, excessive armpit sweating, cerebral palsy and upper limb spasticity. **CC**

A new 'POM to P' solution for heartburn

Pantoloc Control is a new OTC treatment for the burning problem of acid reflux. Containing pantoprazole 20mg, this new 'POM-to-P' switched medicine can be recommended as a first choice treatment for frequent sufferers experiencing two or more episodes of heartburn or acid regurgitation a week.

Pantoloc CONTROL®
Pantoprazole

Between 10-20 per cent of people in the UK experience acid reflux at least weekly,[1] and it can impact on quality of life, leading to avoidance of certain foods and drinks, and loss of sleep.

Some 80 per cent of regular heartburn sufferers complain of night-time heartburn. Over 70 per cent of these people take OTC medicines for relief, but less than a third consider them to be 'extremely effective'.[2]

NICE Guidelines[3] recommend that for many patients self-treatment with antacid and/or alginate therapy may be appropriate for immediate symptom relief. However, additional therapy is appropriate to manage symptoms that persistently affect quality of life.

As a new and effective OTC treatment that stops stomach acid secretion at source, Pantoloc Control offers more complete and sustained relief from acid reflux symptoms than other OTC treatments such as antacids and H2 antagonists.

Give your customers the benefits of Pantoloc Control

Pantoloc Control — key points

- For short term treatment of reflux symptoms such as heartburn and acid regurgitation
- Can be used for up to 28 days' treatment
- For adults over 18 (not pregnant or breastfeeding women)
- Long duration of action - one tablet gives up to 24-hour acid suppression, providing day and night symptom relief
- Effective - gives complete symptom relief in 70 per cent of sufferers after seven days[4]
- Provides sustained relief, but not immediate relief – treatment for 2-3 consecutive days may be necessary to improve symptoms
- Well established safety profile. Some 5 per cent of patients may experience ADRs – diarrhoea and headache are most common

Pantoloc Control turns off acid secretion at source

The parietal cells in the stomach produce gastric acid, and can secrete up to two litres a day. Proton pumps in the parietal cells are responsible for the final step of acid production. Pantoprazole binds irreversibly to proton pumps, thus suppressing acid production 'at source'. This raises the pH of the stomach contents and reduces the severity of heartburn.

Normally triggers such as the sight and smell of food lead to the activation of proton pumps. Such triggers cause nervous and/or hormonal stimuli, leading to production of histamine, acetylcholine or gastrin, that 'switch on' proton pumps.

H2 antagonists reduce acid secretion by blocking histamine receptors, and have no effect on other stimuli. They therefore inhibit acid production to a lesser extent than PPIs such as pantoprazole.

Antacids neutralise acid in the stomach and have no inhibitory effect on acid secretion at all. They only provide short term relief from the symptoms of heartburn, rather than tackling the cause.

www.pantoloc-control.com

References: 1. Dent J, El-Serag HB et al. Gut 2005; 54: 710-717 **2.** Shaker R, Castell DO et al. Am J Gastroenterol 2003; 98: 1487-1493 **3.** NICE Clinical Guideline no 17. Dyspepsia – management of dyspepsia in adults in primary care **4.** EMEA. Assessment report for Pantoloc Control 2009. Doc ref EMEA/374696/2009

Pantoloc Control® 20mg gastro-resistant tablets

Presentation: Yellow tablets containing 20mg pantoprazole (as sodium sesquihydrate). **Indications:** Short term treatment of reflux symptoms (e.g. heartburn, acid regurgitation) in adults. **Dosage and Administration: Adults (including elderly)** one tablet daily. **Children under 18 years:** not recommended. Treatment may be necessary for 2 to 3 consecutive days to achieve symptom improvement. If no symptom relief within 2 weeks consult a doctor. Treatment should not exceed 4 weeks without consulting doctor. **Contraindications:** Hypersensitivity to active, to soya or any of excipients. Co-administration with atazanavir. Precautions: patients should consult doctor in cases of: unintentional weight loss, anaemia, GI bleeding, dysphagia, persistent vomiting, vomiting with blood, previous GI ulcer or GI surgery, symptomatic treatment more than 4 weeks, jaundice, hepatic impairment, liver disease, over 55 years, recently changed symptoms, serious disease affecting general well-being **Interactions:** possible reduced absorption of actives whose bioavailability is pH dependent (eg ketoconazole); reduced bioavailability of atazanavir. As pantoprazole is metabolised by cytochrome P450 enzyme systems possible interactions with substances metabolised by same enzyme system cannot be excluded. **Pregnancy & Lactation:** not recommended. **Side Effects:** Uncommon: headache; dizziness; diarrhoea; nausea/vomiting; abdominal distension, bloating, pain and discomfort; constipation; dry mouth; rash, exanthema, eruption; pruritus; asthenia, fatigue and malaise; sleep disorders, raised liver enzymes. Rare: disturbances/blurring of vision; urticaria; angioedema; arthralgia; myalgia; hyperlipidaemias and lipid increases; weight changes; raised body temperature; peripheral oedema; hypersensitivity reactions; bilirubin increased; depression. Very rare: thrombocytopenia; leucopenia; disorientation. Frequency not known: interstitial nephritis; Stevens-Johnson syndrome; Lyell syndrome; erythema multiforme; photosensitivity; hyponatraemia; jaundice; hepatocellular injury/failure; hallucination, confusion. **Legal Category:** P. **RRP:** 7 tablets: £6.90; 14 tablets: £11.90. **Marketing Authorisation No:** EU/1/09/519/001-004 MA Holder: Nycomed GmbH, Byk-Gulden-Str.2, D-78467 Konstanz, Germany. **Date of Preparation:** February 2010. Further information is available from Novartis Consumer Health, Wimblehurst Road, Horsham, RH12 5AB, UK.
Please refer to SPC for full prescribing information.

Retail talk

Should higher SPF sun cream cost the same as lower factors?

"Yes, because it encourages people to use the higher factors. We know from experience that if customers look along and see that the lower factor's cheaper, they'll take the cheaper one. I have had people saying, 'I know I should have that one but I'll take this as it's cheaper'."
Alison Gibb, The Co-operative Pharmacy, Alness, Ross-shire

"I would think so, yes, otherwise, it might lead to sub-therapeutic use. The customer might need a higher factor but think, 'I'll risk it and see how it goes', so I think they should all be priced the same."
Pradeep Prabhu, Murrays Healthcare, Halesowen, West Midlands

Web verdict

Yes 100%

No 0%

Armchair view: Pharmacists are overwhelmingly in favour of a move to standardise the cost of sunscreen across the different protection factors. This reflects Superdrug's recent promise not to charge more for high SPFs.

Next week's question:
Do you think a rise in VAT to 20 per cent will adversely affect your pharmacy's sales? Vote at **www.chemistanddruggist.co.uk**

Capitalise on the incontinence market – £63.9m and growing
See category focus, page 19

GSK £3m campaign backs launch of fast-acting desensitising toothpaste

GSK Consumer Healthcare has announced the launch of Sensodyne Rapid Relief, a fast-acting, desensitising toothpaste.

The launch will be supported by a £3 million integrated marketing campaign.

A television advertisement depicts a variety of people discussing how they avoid the pain of sensitivity when confronted with an ice cream or an iced drink. The campaign also includes print advertisements, digital activity and PR.

Prices: £2.45/45ml; £3.65/75ml; £4.29/100ml
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Market focus

- The global oral hygiene market is forecast to reach $29.5 billion by 2013.
- Toothpaste sales dominate the global oral hygiene market, generating 57 per cent of its revenue.

Source: Datamonitor, November 2009

Canesten launches online resource for professionals

The Canesten brand has launched an online resource on fungal infections aimed at pharmacists and other health professionals.

The website, www.canesten.co.uk/hcp, has been designed to enhance knowledge of the most common fungal infections and their treatment, says Canesten manufacturer Bayer Consumer Care.

Conditions covered on the website include vaginal thrush, cystitis, athlete's foot, sweat rash, ringworm and jock itch.

Resources available on the website include product information, diagnosis and treatment algorithms, patient information leaflets and an image library, according to the company.

Ceuta Healthcare
Tel: 01202 780558
www.canesten.co.uk/hcp

Pantoloc is on the TV

Pantoloc Control heartburn treatment is the focus of a television campaign from this month.

The advertisement is running on ITV, Channel 4, five and Sky channels, says manufacturer Novartis Consumer Health.

The campaign will be supported by a series of press adverts in national women's lifestyle magazines throughout 2010.

In addition, a PR campaign will rur during the summer months.

A comprehensive POM to P training programme to support pharmacy staff has been rolled out nationwide, adds the company.

Novartis Consumer Health
Tel: 01403 218111

On TV next week

Jungle Formula: All areas
Lanacane Anti Chafing Gel: All areas
Magicool: GMTV, ITV, five
Magicool Plus: GMTV, ITV, five
OdorEaters: All areas
Panadol: All areas
Savlon: All areas
Seabond: All areas
PharmaSite for next week: Zirtek – windows, **Zirtek**– in-store, **Zirtek** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

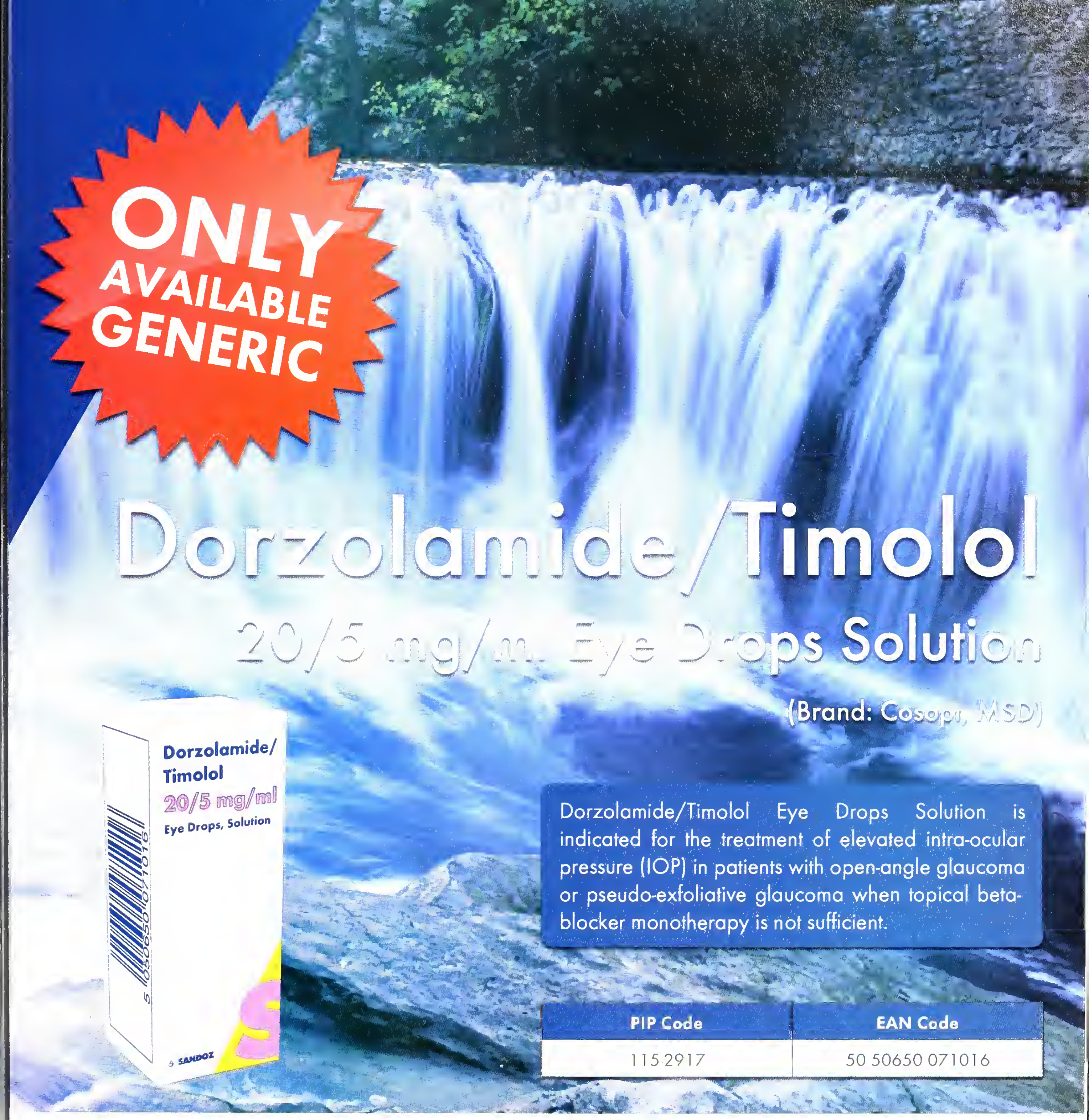
Lynx channels Top Gun in ads

Lynx Dry+ Sensitive deodorant is set to be the focus of a £4 million marketing campaign this summer, featuring a Top Gun-inspired advert, manufacturer Unilever UK has announced.

The multimedia campaign will include video-on-demand, cinema, digital, in-store, sampling, PR and outdoor advertising.

Lynx Dry+ Sensitive tackles both sweat and sensitive skin, says Unilever UK.

Unilever UK
Tel: 01372 945000



Get the industry verdict on the white paper
www.chemistanddruggist.co.uk/healthwhitepaper

Vive la white paper revolution?

Andrew Lansley revealed a radical shake-up in the Liberating the NHS white paper this week. **Max Gosney** asks if pharmacy is bound for triumph or tragedy in the new health republic?

Uncontrollable fist pumping and groans of despair. It's easy to imagine how GPs and PCTs reacted to this week's health white paper. For pharmacists though, the instant reaction to the new government's health vision is less clear cut.

Health secretary Andrew Lansley has laid out a radical reform programme in the Liberating the NHS white paper. Out go red tape, obsessions over targets and political micro management. In come greater patient powers, more qualitative measures and frontline NHS staff empowered to take decisions. Those are the driving themes of the paper, but it's their application to commissioning that will be of most interest to pharmacists.

The standout reform from this paper is the decision to cull all PCTs. Trusts will disappear from 2013, with functions taken on by local GP consortia, a new NHS commissioning board and local authorities. Few in pharmacy will grieve the departure of their local PCT, contractor representatives told C+D this week.

"From a personal perspective, good luck and good riddance," says Hiten Patel, MD at PharmaPlus. "They haven't engaged with community pharmacy. They've got too big and one department never talked to the other."

Celebrating the demise of trusts could be premature, according to Rob Darracott, chief executive of the CCA. Expect one final sting in the tail as PCTs prepare to disband, he says. "Changes like that take place over a 12 to 18 month period. During that time they're more concerned about preserving the job they have rather than the job they have to do. During a major reorganisation there can be a loss of focus."

The passing of PCTs will undoubtedly disrupt pharmacy at a local level. But nationally there are also massive ramifications from their departure. The global sum – pharmacy's bread and butter funding – has sat with PCTs since April this year. Industry insiders suggest the pharmacy pot is likely to pass on to the new NHS Commissioning Board set out in the white paper. But for now it remains a going concern.

The other grey area is the future of pharmaceutical needs assessments. These task PCTs with mapping out local pharmacy services and using the data to determine new contract applications and inform commissioning. Whether the documents due to come into force from 2011 will be lost amid the blood letting to come remains an unanswered question.

The government says this white paper is driven by a desire to shift decision-making as close as possible to patients. And what's clear is GPs seem to be the government's favoured generals. GP consortia will inherit an £80 billion commissioning budget and form 500 hubs for directing local NHS services.

For pharmacists, a gut feeling of a GP whitewash on commissioning is perhaps the most natural reaction to this initiative. But there are caveats. Mr Lansley has gone on record to stress that GPs will not have a monopoly on consortia. The forums will be made up of several different clinicians, including pharmacists.

In fact the consortia are an opportunity rather than a threat, says Steve Foster, superintendent of Pierremont Pharmacy in Broadstairs, Kent. "PCTs have been a mess so their going is not a bad thing. Putting decision-making in the hands of clinicians is a positive move."

GPs will not run away with the format, adds Mr Foster, who also heads the Health Care Professionals Commissioning Network, which was set up to broaden NHS commissioning expertise beyond GPs. "I think there's a very strong message from the top down that GPs can't do this alone. If it's their own money on the line they'll be keen to find the most cost effective way of doing things. And pharmacy can offer that service." A formal incentive between the two professions is also a likely development, the CCA predicts.

Further reassurance for pharmacy comes in the white paper's commitment that its services won't rest solely with GP consortia. The NHS Commissioning Board will oversee pharmacy services, the document stresses. Consortia are likely to have input though. And the jurisdiction over enhanced service commissioning is anyone's guess.

"It will be interesting to see where the commissioning of enhanced services will fall," says Jane Moffatt, head of medicines management at Brighton and Hove City PCT. "I see the responsibility sitting with GP consortia."

Others feel enhanced services might migrate to local authorities, which will take on responsibility for public health. "Enhanced services would sit under public health with the local authorities," Mr Darracott told C+D. "It's unclear at this point. We're back to waiting for what the detail is."

That lack of detail was one major criticism of this white paper from within government, according to Whitehall insiders. The document – 61 pages compared to 141 for the pharmacy white paper of 2008 – is a mission statement rather than an instruction manual. The gaps will be filled in a plethora of consultations in the future.

For now, Andrew Lansley's white paper remains a distinct shade of grey for pharmacy.

Reasons to be cheerful

- PCTs are to be abolished and replaced by a national commissioning board – this could end patchy commissioning of pharmacy services.
- New GP consortia will not solely commission pharmacy services.
- The paper explicitly praises the important and expanding role of community pharmacy services.

Reasons to be fearful

- GP consortia will have an influence over pharmacy services and question marks remain over the extent of pharmacy representation on the forums.
- Control over the commissioning of enhanced services is unclear.
- Years of upheaval at PCTs that could hold back pharmacy commissioning.

What's your verdict on the health white paper?

Join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist – or email your views to max.gosney@ubm.com

Making the best decisions – do the maths

"I WANTED TO SHOUT, 'I KNOW BEST, SO DO AS I SAY AND JUST TAKE THE BLOODY TABLETS!'"

I like to think of myself as an advocate for the profession. Pharmacy has been good to me – as much as any demanding, uncertain, stressful profession can be – so I agreed to be shadowed by an A level student thinking through career options.

We got to discussing patient information leaflets, and I smiled at her confusion as I explained how lists of side effects stopped many people taking the medication they needed. "That's silly" she said, "Why don't they do what's for the best?" Ah – the simplicity and innocence of youth.

Despite the 'Broken Britain' image of insolent teenagers portrayed by the press, we do tend to believe and obey those who are senior to us in position and age. But part of the maturing process sometimes moves us from testing and challenging the world in a healthy way to cynicism and doubt. "I don't want the cheap generic – they're not as good as the brand!" "I don't need the cream as well as the pessary – you're just trying to make more money!" "Why is it out of stock – has it been withdrawn?"

It's hard to gauge risk and probability, which is why at odds of 14 million to one we're still prepared to chuck a pound away on the National Lottery for the possibility of a large benefit from a small outlay. Hey, even I'm prepared to gamble £4 a week on the PLB actually making a beneficial difference to my working life.

So we fear our teenagers will do drugs, when they're 20 times more likely to die from alcohol abuse, and every time there is a health scare more people are harmed by lack of treatment – as we saw with the MMR panic.

And what hope when even scientists don't support what is in the health interest of the nation? I was appalled to read that the majority responding to last week's C+D poll would not accept the swine flu vaccination when the risk benefit ratio means we should jump at the offer.

So how can we overcome the perception problem? It seems medical fears are like the Lotto in reverse, promising £1 a week for life, but with a 14 million to one risk of losing a fortune.

Today I told a man that his 10-year cardiovascular risk was 20 per cent, and that to take his antihypertensives could reduce that by a quarter. "So they're only helping five people in a hundred?" he asked. "No. Well, yes, in a way, but..." and I floundered to justify what should be such a simple choice, wanting to shout: "I KNOW BEST, SO DO AS I SAY AND JUST TAKE THE BLOODY TABLETS!"

But of course I don't know what's best for him, I just picture the maths in a different way, and we all know that good health isn't just absence of disease. That's the problem with concordance – it's not about what's the right thing to do, but about our right to decide what's for the best.

Building relationships in a time of change

I write this prior to the publication of the coalition government's NHS white paper, but I have a strong sense that even after the details emerge there will still be more questions than answers.

I am sure pharmacists across England will agree with Mr Lansley that GPs, who are responsible for the majority of NHS spend, should be fully engaged in decisions about how patient services can be made more responsive and more cost effective. We know however that many GPs will not welcome the financial risk and the managerial burden of managing budgets that this will bring.

In the meantime, we need to understand how pharmacists can become involved in new commissioning consortia and help shape new models of integrated care. Will the new regime impact the way pharmacy is funded, the construction of the pharmacy contract and the global sum? Will the principle of rewarding outcomes be applied to the profession? That would change everything.

At Lloydspharmacy we are already considering how we can be more flexible in our approach to local healthcare issues. Equally, I predict that flexibility will be required at LPC level. To date they have been the profession's interface with PCTs. Can they now adapt to also deal with the new local commissioners?

I also wonder whether, since the focus of GP commissioning will inevitably be secondary care services, the time has arrived for pharmacy to step forward and demonstrate the role it can play in keeping people out of the expensive bits of the healthcare system in the first place?

As a pharmacist I know exactly what potential lies within our profession. With our ready-made accessible healthcare network, our colleagues in general practice should be looking to pharmacy to support new local commissioning and we in turn should build these relationships and get involved.

Ask yourself this. Do we represent a viable option for them to commission services from? Can we support the new NHS? One thing is clear – we must adapt as a profession. Whether we like it or not, our role has evolved into a commoditised function. Our future lies in our powerful customer-pharmacist relationships, our vast healthcare expertise, our ability to add value to patients' health and to improve their quality of life. You do it every day. We don't document it. This will change.

Whatever the future holds and however deep the uncertainties, pharmacy should be a full and willing partner in the new NHS. Never before has the profession had such opportunities to come in from the margins of healthcare and forge partnerships with other clinicians to improve the health of the communities they serve.

Ronan Brett, head of professional and external relations, Lloydspharmacy

"WHETHER WE LIKE IT OR NOT, OUR ROLE HAS EVOLVED INTO A COMMODITISED FUNCTION"

I believe pharmacists should become elitist

"AN ELITIST ATTITUDE STARTS WITH THE EDUCATION SYSTEM, BUT MANY PHARMACY STUDENTS LOSE THEIR ATTRACTION TO THE PROFESSION DURING THEIR STUDIES"

Elitism may sound like an unsuitable characteristic for a pharmacist, but what does this mean? In my opinion, it means that pharmacists should not believe themselves to be, nor be perceived as, second rate healthcare professionals, behind doctors and dentists, but rather their equals. It means that pharmacy students should feel enthused about the journey they are about to embark on. It means newly qualified pharmacists should want to stay in the profession.

This elitist attitude starts with the pharmacy education system. Having recently been through this system myself, it is clear that many students lose their attraction to the profession during their studies.

The development of an MPharm degree is no easy task, as pharmacy encompasses so many different areas. The majority of MPharm courses attempt to strike a balance between the fundamental sciences and the practice elements of the profession. However, a recent study by Wilson et al showed that less than 30 per cent of students considered science-based practicals useful. Compare this to the 92 per cent of students who thought that dispensing practice was of benefit to them and you can see where attitudes begin to change. If students were more aware of what they could potentially do as a pharmacist then the science/practice balance could be somewhat restored.

Institutions need to do their part in promoting the multitude of diverse careers that pharmacists can follow. The roles which pharmacists can take up are numerous, yet to the average pharmacy graduate remain unknown.

Opportunities such as working in public health for the World Health Organization or as a biotechnologist for the ministry of defence are all available to pharmacists due to their broad skill base. Even the traditional roles of community, hospital and industrial pharmacy have diverse ranges that are not promoted successfully during undergraduate studies. Are we not supposed to be creating all-rounders – graduates who have the transferrable skills for any job they choose?

The problem is the availability of these opportunities. For example, in 2006 there were only 14 industrial pre-reg places available. For such an important part of the pharmacy chain, is this really representative at pre-reg level? In this credit-crunched world companies will cite that pre-reg programmes are not a worthwhile investment due to training costs, etc but this is where our professional bodies and the Association of British Pharmaceutical Industry must step in and promote the potential career paths for pharmacists in industry.

Pre-registration programmes in hospital, on the other hand, are widely promoted and available. Hospital pharmacists play a key role in ensuring hospital healthcare is provided effectively and efficiently, yet why is this role not rewarded? Agenda for Change was meant to provide better rewards for pharmacists yet why is there not the parity with doctors and dentists, which was the intention in the first place? On what basis were both the medical and dental professions allowed to opt out of the scheme whereas pharmacists had to stay? Our role is just as important in the functioning of the NHS as doctors and dentists so the rewards should be of a similar ilk.

Community pharmacy has a stigma attached to it that needs to be shifted. Many patients are not aware of the skills that a pharmacist possesses; equally pharmacists are not given opportunities to showcase these skills. Extra services give pharmacists a chance to broaden their horizons but is enough being done to alter the public perception of the community pharmacist?

Some patients appear surprised to be receiving medical advice from a pharmacist. Should this really be such a shock? Gaining the respect of the general public is paramount in not only providing an effective service but also creating a strong social healthcare network. This particular topic has been discussed over a number of years, yet we are still seeing the same problems come up time and again. It is changing, but is it changing fast enough?

Many, if not all of the points I have raised have been covered in this very publication time and again. Yet, why are we still talking about them? I believe it is due to our collective attitude. We, as a profession, need to realise that we truly belong at the centre of healthcare. In a world where healthcare is in a constant state of flux, we need to ensure that our profession stands up to the rigours of the future. Pharmacy should be at the core of the NHS and yet always appears to be on the periphery compared to other professions. This is indicative of a profession that has not realised its own importance within the healthcare system.

This brings me full circle to elitism. Perpetuating a feeling that we truly belong at the centre of healthcare is not easy and some of the issues I have highlighted will impede that process. However, if we collectively strive towards solving these problems then we become inherently stronger. If we continually look to improve our profession then not only do we improve the public and other healthcare professionals' perception of us but we improve the perception of pharmacy for ourselves. That is more important than anything else.

Adnan Khan is a pharmacist and PhD student

Why pharmacists need to be elitist: the stats

In 2008 there was a 13 per cent vacancy rate for hospital pharmacists.

25 per cent of NHS pre-regs never take up a permanent position with the NHS.

In 2002, MORI classed pharmacy as a 'non manual' profession, alongside technicians, salesmen and clerks.

As of 2006, 87 per cent of patients stated they would prefer to receive information about medicines from a GP than a pharmacist.

Is elitism the mechanism that will put pharmacy at the centre of primary healthcare? To have your say on Adnan's argument or to submit your own opinion piece, email us at the address below. Don't forget to include your contact details.

haveyoursay@chemistanddruggist.co.uk

10 THINGS YOU NEED TO KNOW ABOUT...

World Cup malaise

With football fever now dying down (except in Spain), **Chris Chapman** explains what to look out for in customers returning from South Africa beyond vuvuzela-inflicted hearing loss, including conditions virtually non-existent in the UK

1 Most travellers who have taken sensible precautions – such as vaccinations, avoiding contaminated drinking water and using protection during sexual intercourse – have a low risk of developing health problems on return from the World Cup. Risk is increased by failing to take precautions, for example not using condoms during sexual intercourse, or by visiting rural areas.

2 Of those who do develop problems, the most common will be gastrointestinal upsets. Patients with traveller's diarrhoea should drink enough fluids, taking oral rehydration salts if necessary. Patients should be advised that if their diarrhoea becomes very frequent, very watery, contains blood or lasts for more than three days they should seek medical attention as an emergency. There have been outbreaks of cholera in South Africa.

3 It is currently winter in the southern hemisphere. Travellers to South Africa are therefore at increased risk of both seasonal influenza and swine flu. Treatment does not vary from current UK recommendations.

4 Sexually transmitted infections (STIs) are a significant problem in South Africa. Around 8 per cent of the population have hepatitis B, and a 2008 report by the UNAIDS/WHO working group estimated that around 5.4 million 15 to 49-year-olds in South Africa had HIV, giving a prevalence of more than 18 per cent in this group, compared with around 0.2 per cent in the UK.

5 Patients who are concerned they may have an STI should be referred for testing. The current British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and the British Infection Society (BIS) guidance recommends all patients returning from South Africa who may have an STI should be tested for HIV.

6 There is a high risk of malaria in South Africa in the low altitude areas near the Mozambique and Zimbabwe borders, including Kruger National Park, and northeast KwaZulu-Natal to as far south as Jozini. The risk of malaria in cities is low. However, malaria is the most commonly imported tropical disease into the UK, with 1,500 to 2,000 cases a year.

7 Malaria has no specific symptoms. It can include fever, headache and general malaise, and can be mistaken for non-specific viral infection or influenza. Most cases are caused by Plasmodium falciparum and usually present within months of exposure. If malaria is suspected, it is a medical emergency and patients should be referred to a hospital for a blood test immediately.

8 In April, there was an outbreak of Rift Valley Fever in the provinces where England played two of their group games. The fever, which is transmitted by mosquitoes, has an incubation period of one to six days and causes influenza-like illness. Patients usually recover in four to seven days, but complications can cause death in 1 per cent of cases.

9 South Africa has a high incidence of tuberculosis. However, the National Travel Health Network and Centre (NaTHNaC) says the risk of tuberculosis for most travellers is low. Travellers who suspect they have been exposed should be referred for a medical evaluation.

10 Other diseases known to occur in South Africa also include rabies, hepatitis A and typhoid. There is no risk of yellow fever.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on travel health

REFLECT	Am I confident providing travel health advice to customers?
PLAN	Use this article as a prompt to consider the areas of travel health you need to revisit.
ACT	Attend training on or revise identified areas.
EVALUATE	Am I better able to provide customers with travel health advice?

Update
Your weekly CPD revision guide

End of life care: part 1

The first of two articles considers options for pain control in palliative care

60-second summary

This article, which can be used for CPD reviews pharmacological approaches to managing persistent and breakthrough pain. It should help you improve the experiences of patients, their caregivers and other professionals who come to you for help.

Which are the main analgesics used in palliative care?

Morphine is the standard against which other analgesics are compared. Oxycodone is about twice as potent and slightly less sedating. Fentanyl is about 100 times more potent than morphine and can be administered as transdermal patches.

What about breakthrough pain?

Oral morphine is used in about one sixth of the daily dose being given for background analgesia. Transmucosal, buccal and nasal fentanyl preparations act more quickly and may be useful for patients who experience side effects with other immediate-release opioids.

Doreen Cochrane MRPharmS

In 2008 the Department of Health published an End of Life Care Strategy to bring about a "change in access to care for all people approaching end of life". It was envisaged that improvements would be achieved using a systems and care pathway approach for commissioning and providing integrated services, improving co-ordination. It would involve workforce development to effect relief of suffering, enhance quality of life and support for patients and their families and encourage initiation of palliative care early in a patient's illness, even when he or she is still receiving life-prolonging treatment. It supported the use of the Gold Standards Framework, the Liverpool Care Pathway and Preferred Place of Care tools. However, the needs of carers and professionals involved in providing palliation and end of life care for patients with non-malignant disease, including neurological diseases and dementia, cardiovascular, renal and respiratory diseases, and for children and people with learning disabilities remain poorly supported.

The End of Life Care in Primary Care 2009 audit identified improvements needed to help more people die in their own homes. These include better access to medicines, proactive planning to improve clinical management of complex problems, carer information and support, and hospital discharge planning and liaison.

Pain management

Pain is the most common symptom of cancer. It occurs in up to 90 per cent of patients with advanced disease and about 67 per cent of patients with non-malignant illness. Moderate to severe background (persistent) pain and breakthrough cancer pain (BCP) can, in most cases, be treated successfully with opioid analgesics and adjuvant drugs. Treatment or avoidance of the underlying cause of pain may be important. Psychological distress also impacts on pain tolerance.

Care is needed with prescriptions for children or elderly patients and for those with impaired renal or hepatic excretion. Appropriate assessment and re-assessment of pain is important both at initiation of opioid treatment and when converting from one opioid to another – see the table opposite for equivalent doses. Dose titration according to pain control or adverse effects may be required.

Opioid treatment is not thought to carry a high risk of addiction in patients suffering chronic pain, a point that may be worth mentioning to some patients who are reluctant to take such medication.

Opioids in common use

Morphine This potent analgesic is used in the treatment of moderate to severe cancer pain and is the standard against which other analgesics are compared. It can be administered by the oral (immediate and modified-release formulations), rectal and parenteral (sc, im, iv), spinal and epidural routes for pain management. Oral (Oramorph, Sevredol, Morphgesic, MST Continus, MXL, Zomorph) or rectal administration leads to 70 per cent first pass metabolism in the liver and metabolites are largely excreted by the kidney. Reduced excretion rates may lead to sedation or respiratory depression. A 25 per cent dose reduction is recommended if the patient's creatinine concentration is in the range 150-300mmol per litre. With more severe renal impairment, dose reduction and frequency change is required. The side effects of euphoria or dysphoria and itching are also common.

The RPSGB Practice Committee does not recommend routine brand-name prescribing of modified-release morphine but states that pharmacists should take steps to prevent the unintentional change of the brand supplied to patients.

Diamorphine Diamorphine is about twice as potent as morphine. It is available in powder form for reconstitution and is essentially a pro-drug – it is activated by deacetylation to morphine. It has a faster onset of action than morphine and a shorter duration of action, especially when administered intravenously. Diamorphine injection is usually included in 'Just in Case' boxes for anticipatory end of life care.

Oxycodone Oxycodone is about twice as potent as morphine. When taken orally it undergoes first-pass metabolism in the liver (50 per cent). It is slightly less sedating than morphine and is available as normal release (OxyNorm capsules and liquid), sustained release (Oxycontin) and a parenteral formulation (OxyNorm). It is also available in the compound preparation Targinact (see p16). The manufacturers of oxycodone advise against its use in patients with severe renal failure.

Fentanyl Fentanyl is about 100 times more potent than morphine. It is usually administered from a transdermal patch delivery system (Durogesic DTrans, Fentalis, Matrifen, Mezolar, Osmanil, Victanyl). The transdermal preparation is available in a reservoir (Durogesic) or matrix formulation and provides 72 hours of potent

analgesia. Reservoir patches of fentanyl should never be cut to deliver a smaller dose because this disrupts the drug-release mechanism. A patch releasing 12mcg per hour of fentanyl allows for greater ease of titration, especially for patients for whom side effects may be problematic.

The RPSGB Practice Committee has advised there is no evidence of a difference in the rate of delivery of fentanyl patches of different brands when used in accordance with the product licence. However, manufacturers advise against brand changes and recommend counselling to ensure the patient and carers understand the reasons if such changes become necessary. Parenteral administration of fentanyl is generally only used when close continual clinical monitoring is available.

Side effects

It is important to counsel patients and caregivers about side effects associated with use of opioids. Nausea and vomiting occur in about two thirds of patients starting opioids and last for up to seven days; these side effects are uncommon when the opioid dose is stable. An anti-emetic may be prescribed at initiation of opioid prescribing. Sedation is a common side effect occurring usually in the first five to seven days of treatment and may affect some patients' ability to drive.

Constipation is a very common and persistent effect of oral opioids, occurring in up to 90 per cent of patients. Treatment for opioid-induced bowel dysfunction will be reviewed next week in the second Update article in this series. Prophylactic laxatives should be prescribed on an individual basis for patients starting long-term opioids.

Two new medicines containing opioid antagonists have been introduced. These are subcutaneous methylnaltrexone (Relistor) and a combination product containing oxycodone and nalaxone (Targinact), in a ratio of 2:1 opioid to naloxone, for oral administration.

Methylnaltrexone has been approved by the Scottish Medicines Consortium for restricted use by palliative care specialists "when response to usual laxative therapy has not been sufficient". It will not be reviewed by Nice as its impact on population health and NHS budgets does not warrant the resources required to conduct this type of appraisal.

Breakthrough cancer pain

Breakthrough cancer pain (BCP) has been defined as "a transient exacerbation of pain that occurs either spontaneously or in relation to a specific predictable or unpredictable trigger despite relatively stable and adequately controlled background pain". The typical episode reaches peak intensity within three minutes and is of short duration (median 30 minutes).

Assessment is important to allow identification of any underlying cause and re-assessment of the treatment of background pain. For many years, the only pharmacological treatment option for BCP or incident pain (eg caused by a procedure or movement) was immediate release morphine or oxycodone equivalent to about a sixth of the daily dose of oral opioid.

Oral transmucosal fentanyl is now marketed specifically for the management of breakthrough pain. Three products are licensed: Actiq lozenges (lollipop), Abstral sublingual tablets and Effentora buccal tablets. They have a faster onset of action than immediate-release oral formulations of morphine or oxycodone (10-15 minutes compared with 20-30 minutes) and a shorter duration of action (one hour compared with four to six hours). The transmucosal formulations are licensed for use in patients taking at least 60mg of oral morphine per day, or an equivalent dose of another opioid (eg 25 microgram transdermal fentanyl per hour, 30mg oral oxycodone daily), for at least a week. With all these products the rescue dose cannot be predicted from the background opioid dose, so titration is necessary.

Intranasal fentanyl (Instanyl) has recently been introduced for the management of breakthrough pain in adults who are already receiving opioid therapy for background pain. The initial dose is 50 microgram (one spray) repeated after 10 minutes if necessary. Another intranasal formulation (Nasalfent) may soon be marketed.

Immediate-release fentanyl products are useful for relieving BCP for patients who experience sedation or other side effects after other immediate-release opioids.

Anticipatory dying

Around 65 per cent of people on a care register dying at home or in a care home receive anticipatory prescribing. The Just in Case Box is dispensed for use in the treatment of an individual patient and is held in the patient's room. It is stocked with medicines that may be used when the healthcare team agrees the patient is in the dying phase. Examples of good practice in the supply, storage and safe use of these medicines are available at the Gold Standards Framework website.

Table 1. Equivalent potencies of oral opioids to oral morphine

Oral drug	Duration of action (hours) (standard release preparations)	Potency equivalence to morphine (oral to oral)
Buprenorphine	6-8	80 (sublingual)
Codeine	3-6	0.08-0.15
Dihydrocodeine	3-6	0.1
Hydromorphone	4-5	3.5-10
Morphine	3-6	1
Oxycodone	3-6	1.3-2
Pethidine	2-4	0.1-0.125
Tramadol	4-6	0.1-0.2

Equivalent potencies are only approximate and can be unpredictable. When converting from one opioid to another, it is often appropriate to use a lower dose than the suggested equivalence above. Close monitoring for side effects and efficacy is mandatory, especially at higher doses. A fuller version of this table, including drug notes, is available at www.chemistanddruggist.co.uk/update

Source: National Electronic Library for Medicines (www.nelm.nhs.uk)

Future developments

The Good Practice Guide in the Management of Controlled Drugs, updated in 2009, provides recommendations on the safe possession, storage, supply, and administration of controlled drugs. At present nurse and independent pharmacist prescribers may not prescribe, possess, supply, offer to supply, administer and give directions to administer controlled drugs specified in schedules 2 to 5 of the Misuse of Drugs Regulations 2001. The regulations may be amended to allow this to happen in the future.

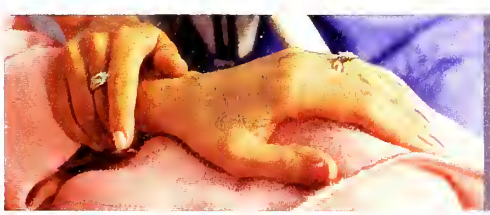
Every year about half a million people die in England. The number of deaths is set to rise due to an ageing population and greater prevalence of long-term conditions. Community pharmacists actively contribute to multi-professional teams involved in palliative and end of life care for patients through dispensing for patients receiving care in the community, care homes, hospices and from out-of-hours services.

By completing training programmes relevant to local and national services, members of the pharmacy team can ensure appropriate access of medicines, contribute to symptom management and allow patients to feel supported in their preferred place of care.

Further reading is available in the full version online at www.chemistanddruggist.co.uk/update

Doreen Cochrane MRPharmS is an independent pharmacist and trainer

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p18).



NEXT WEEK
The management of problems such as constipation, nausea and agitation in end of life care

End of life care: part 1

Reflect

Plan

How does renal impairment affect morphine dosing? How much more potent than morphine is oxycodone? Which opioid analgesic is most effective for breakthrough cancer pain?

This article discusses end of life care, focusing on pain management. It includes information about morphine, diamorphine, oxycodone and fentanyl. It also discusses breakthrough cancer pain and future developments.

- Read more about pain control in terminal care on the Patient UK website at http://tinyurl.com/painrelief10. A diagram of the WHO analgesics ladder can be found on the Pain Talk website at http://tinyurl.com/painrelief20.
- Revise your knowledge of the doses and formulations of the opioid analgesics available by reading section 4.7.2 of the BNF.
- Find out more about breakthrough pain by reading the information for professionals from breakthroughcancer pain.org at http://tinyurl.com/painrelief30 and about Just in Case boxes from the Gold Standards Framework at http://tinyurl.com/painrelief40.
- Consider the aspects of pain management in the end of life care of patients you have known. How could you improve your services?

Act

Are you now confident in your knowledge of pain management in end of life care? Could you give advice about this to a patient or carer?

Evaluate

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What have you learned?

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

Antibiotic prescribing in epilepsy

John Rose, a regular patient at the Update Pharmacy, has just handed in a prescription for ciprofloxacin 250mg tablets, one bd for five days. In the dispensary pharmacist David Spencer reviews it and remembers that John has epilepsy.

He recalls that a couple of days earlier John had come in asking for advice about lower urinary tract symptoms that he was suffering. David suspected that it might be a UTI and referred him to his GP.

David brings up John's PMR on the computer, which shows that he is 36 years old and has a long history of epilepsy that has been successfully controlled for several years with carbamazepine 600mg bd, and that he takes no other prescribed medication. David goes out to speak to John.

"Hi," he says, "I see that Dr Berkoff has prescribed you some antibiotics."

"Yes. She thought your suspicion that I had a water infection was right, took a urine sample to send away to confirm it and prescribed these tablets."

"I don't suppose she told you why exactly she prescribed these?"

"She did actually. She said it wasn't the antibiotic that she would usually give for a water infection, but that those might react badly with my epilepsy tablets. And she said something about them 'upsetting my folate', but I don't know what that means. She's also sending me to the hospital for a blood test, and said I needed to have one regularly."

"How are you getting on with the carbamazepine?" David asks.

"Fine. I haven't had a seizure in years," John replies.

"Alright," David says, "I think I'll just have a word with Dr Berkoff before I dispense your prescription."

Questions

1. What is the problem that David has identified in relation to the prescription?
2. What other drugs might cause the same problem?
3 What did Dr Berkoff's remark about folate mean and was it justified?
4. How often should John have a blood test?

Answers

1. Ciprofloxacin is an inappropriate choice of antibiotic as quinolones are known to trigger seizures or lower seizure threshold in patients prone to them. Trimethoprim is a suitable choice (see 3, below).
2. Analgesics: NSAIDs, opioids; antibacterials: cephalosporins, penicillins; antidepressants: most classes and particularly tricyclics; anti-emetics: metoclopramide, prochlorperazine, cyclizine; antipsychotics, especially chlorpromazine, clozapine; cholinesterase inhibitors: donezepil, galantamine, rivastigmine.
3. Trimethoprim increases the plasma concentration of phenytoin and also has an increased antifolate effect, but there is no such interaction with carbamazepine. In any case, the risk of folate deficiency even with phenytoin is unlikely with a short course of trimethoprim for a UTI.
4. Carbamazepine can cause transient leucopenia and the incidence is high (10-20 per cent); a full blood count should be undertaken every three to six months during the first year of therapy. Carbamazepine is an enzyme inducing drug and a full blood count plus liver enzymes test should be undertaken every two to five years thereafter.

Based on case study 1, C+D Skills for the Future: MURs in Practice. Programme 2, no. 12. March 2006

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CATEGORY FOCUS

Incontinence

Help customers to overcome the embarrasment of bladder weakness and you could see your share of this growing market soar, finds **Emma Wilkinson**

Incontinence may be an embarrassing problem, but it is also a very common one. Prevalence very much depends on who you ask and how you define the condition, but in its 2006 guidance Nice estimated that more than a third of women suffer urinary incontinence from time to time.

Around 4 to 7 per cent of women under 65 and 4 to 17 per cent of those over 65 suffer from the problem on a daily basis. And it is not just a female problem – it is thought that one in 13 of the entire adult population buys incontinence products. Yet according to the Bladder and Bowel Foundation, many people do not seek help or, when they do, receive substandard care.

From the pharmacist's point of view, demand for incontinence products is on the rise, with the bladder weakness market seeing double digit year-on-year growth in sales of pads, liners and pants. Tena dominates the market, perhaps unsurprisingly given the extent of its marketing campaigns, but own label products are starting to come into their own.

Reassuring customers

The big question is how pharmacists can best support customers who feel nervous about shopping for and asking questions about products for bladder weakness.

Five tips for boosting incontinence product sales

1. Invest in staff training to help both pharmacy assistants and customers feel more comfortable talking about incontinence.
2. House your incontinence section within the feminine hygiene category.
3. Take time to assess possible causes of bladder weakness with patients, such as medication side effects.
4. Offer dietary and lifestyle advice to help customers cope with bladder weakness.
5. Ensure customers know that their concerns can be discussed professionally and discreetly, such as in a private consultation room.

Market Insight: Incontinence products

The incontinence market is purchased by 7.5 per cent of the adult population, and shows strong growth year on year.

Own label products are becoming more prominent as the market matures, and are growing faster than brands. However, Tena remains in number one position, with a strong presence across all sub-categories.

As well as having the most expensive products, bladder weakness pants are the fastest growing area in value terms.

Due to the nature of the market, over-45s account for approximately 90 per cent of sales, but as awareness of the condition increases there is opportunity to attract younger buyers.

The pharmacy sector has seen strong value growth faster than the total market this year, especially within the pants sub-category.

Boots is particularly dominant, accounting for a large percentage of sales, but as the incontinence market becomes less specialist, Tesco, Asda and Sainsbury's are increasing share year on year.

Grocers in general are more prominent this year, with shoppers now purchasing in Tesco, Sainsbury's and Morrisons more frequently than in pharmacies.

The pharmacy sector is especially strong in the pants sub-category, which is considered more specialist.

Market changes 2009-10 Incontinence products

Total market value
£63,870,000 ▲ 22.3%

Pharmacy
£14,235,000 ▲ 24.6%

Branded v own label

Total market
Branded
£47,782,000 ▲ 17.8%

Own label
£16,088,000 ▲ 38.3%

Pharmacy
Branded
£7,084,000 ▲ 7.7%

Own label
£7,152,000 ▲ 47.6%

Source: Kantar Worldpanel, 52 weeks to May 16, 2010
Data and analysis provided for C+D by Kantar Worldpanel (strategic insight director, Tim Nancholas)

KANTAR WORLDPANEL

Karl Baggott, category manager at Lloydspharmacy, believes that one key element is making sure customers are buying the most appropriate product for their needs so they will be satisfied and return to the store. He adds: "We know that some people may feel embarrassed when buying incontinence products but pharmacy can offer a discreet environment, which helps to take away the embarrassment factor, enabling customers to ask questions about products and pharmacists to advise customers on products that are best suited to their needs."

To ensure the pharmacy team is able to offer appropriate, helpful advice it may be worth investing in some training.

In the spring of this year, Numark ran training workshops aimed at pharmacy support staff in conjunction with SCA Hygiene Products, which manufactures Tena. Those taking part were advised not only on technical knowledge regarding different types of bladder weakness and pros and cons of different types of incontinence products, but also tips on how to encourage customers to talk with minimum embarrassment.

The training led to a 100 per cent boost in sales of Tena products in the stores taking part.

Yvonne Tuckley, training manager at Numark, says it is vital to involve counter assistants in being able to advise on incontinence. "Customers are likely to feel awkward and embarrassed, which may deter them from seeking advice," she says, "and without proper training pharmacy staff may feel reticent to discuss the subject, too."

Once staff are comfortable talking about and advising on bladder weakness, it is also vital that nervous customers are easily and quickly able to find what they are looking for. Emma Charlesworth, retail excellence manager at Numark, says: "The customer needs to feel at ease in terms of making a purchasing decision. Even though recent development in the category has meant that incontinence is no longer stigmatised there still exists some embarrassment around the issue, therefore helping your customers to avoid any embarrassing conversations will ultimately lead to increased sales."

She recommends using recognisable brands to direct customers to the section, which is best housed within the feminine hygiene category. "Having a poorly merchandised female health section will ultimately drive customers away from the category and because this category is 'needs' rather than 'wants' focused, an illogically merchandised section will drive them out of the store," Ms Charlesworth explains.

Practical advice

The pharmacist also needs to take the time to properly assess why a patient is suffering from incontinence and if there are any simple steps that can be taken to alleviate the problem. For example, says Wendy Lee, pharmacist at The Co-operative Pharmacy, it could be a side effect of a medication the patient is taking.

"Sometimes patients take diuretics too late in the day and they end up needing to go to the toilet at night time but they may not be able to get there quick enough," Ms Lee says. "The pharmacist can also establish whether patients are drinking lots of caffeinated drinks as these have a diuretic effect.

"Drinks containing barley or dandelion in addition to tea, coffee and cola may also have a diuretic effect."

She adds that dietary and lifestyle advice can sometimes make a big impact on patients' quality of life. Simply advising patients to avoid drinks that have a diuretic effect and not to drink too much just before they go to bed may make all the difference.

And explaining that there is a range of medication and incontinence products on the market to help to solve or alleviate these problems can really put a patient at ease. "Reassure them that their requests can be dealt with professionally and discreetly," Ms Lee adds.

"Sometimes customers don't want to come in personally to discuss this matter in the pharmacy so we can encourage them to ring in and discuss this with the pharmacist in confidence. Always offer the customer the option of a private consultation."

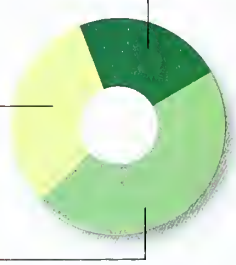
How the sub-categories compare

Total market

PANTS
£14,387,000
+58.9%

LINERS
£19,981,000
+15.4%

PADS
£29,417,000
+13.8%



Pharmacy

LINERS
£2,136,000
+37%

PADS
£4,312,000
-12.6%

PANTS
£7,703,000
+56.2%

Source: Kantar Worldpanel, 52 weeks to May 16, 2010

KANTAR WORLDPANEL

Case study

Since the Tena/Numark incontinence training seesion, staff from Norwich's Natural Health Pharmacy have been more confident in assisting customers who may be embarrassed about asking for advice

NATURAL HEALTH PHARMACY, NORWICH
DEIDRE WHYATT AND ANN SMITH

Deirdre Whyatt, from Natural Health Pharmacy in Norwich, took four of her staff along to an incontinence training session organised by Numark and SCA Hygiene Products, which manufactures Tena.

They were taken through the range of products offered by Tena and given an explanation about which product to use in what circumstances and how best to arrange those products on the stock floor to enable the customer to quickly and easily find what they are looking for.

Retail supervisor Ann Smith says: "We have put into practice the training given, the shelves have been arranged according to the trainer, the boxes are in order and the customer can see her way clearly."

She adds: "The display is private but prominent, the customer is happy to ask for advice and we are more confident to give the advice – personally I have not lost a sale since that evening and Tena is one of our biggest sellers in this area."

She says people are often embarrassed about discussing incontinence, but since the training staff have been able to spend more productive time with customers, who come back time and again for more help.

"We are also often asked for products for gentlemen and are happy to discuss this with our customers, who appreciate a matter of fact understanding of their problem," Ms Smith says.

"I would recommend this sort of training to all who work in this business as customers are happy and relieved to be helped to spend their money on the right product instead of trying lots of different ones first."

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on incontinence

REFLECT	Do I offer customers with incontinence a good service?
PLAN	Consider how I could better serve customers with this condition.
ACT	Organise training for myself and staff and/or remerchandise my incontinence products section.
EVALUATE	Are customers with incontinence better served in my pharmacy?

Brand Watch: Tena

Tena, a range of more than 70 incontinence products, undoubtedly dominates the bladder weakness market – a category showing strong year-on-year growth.

Tena brand marketing manager Emma Lazenby says there are approximately six million women and three million men in the UK who experience bladder weakness.

Through mainstream advertising aimed at both men and women, the Tena name is certainly one that resonates with consumers.

And although incontinence products are available through many retailers, the pharmacy is able to provide an extra level of service, she says.

"Tena Men has proved very successful in pharmacy. We offer both level one and level two product in pharmacy, whereas in most other retailers we only offer level two.

"This provides a point of differentiation for pharmacies and allows pharmacists to be able to talk about the full range of products directly with the consumer."

In addition, she says, pharmacists are able to advise based on the patient's needs, and in some cases offer private consultation rooms.

"Tena offers a training course for pharmacists and counter staff to help them feel more comfortable in approaching consumers who are reluctant to discuss their situation," Ms Lazenby adds.

The coalition script

While this week's health reforms dominate the news agenda, the coalition government's policies on tax, employment law and consumer rights will also affect pharmacies. **Chris West** and **Adam Bernstein** explain what the changes mean to you

The coalition's policies on tax and business will affect phamacy as much as their health reforms

And so it came to pass. After much pre-election angst, warning how destructive a hung parliament would be, the public declined to give any party the majority required to form a government. In the extraordinary days that followed a coalition government emerged, pledging an era of new kind of politics.

From day one, the talk was predictably all about the deficit and the need to tighten public spending. While health spending will be protected, the government is still committed to finding the £15 to £20 billion of savings identified by NHS chief executive David Nicholson – "more for less" is the mantra.

On health policy, there have been few surprises. The Queen's Speech set out the government's legislative programme, including a health bill making provision for GP commissioning, an independent NHS Board and huge cuts within the Department of Health and NHS management, with strategic health authorities and primary care trusts bearing the brunt.

The revised operating framework, issued a month after the election, was Andrew Lansley's first opportunity to begin unpicking the parts of the NHS that don't fit his future plans. 'Process targets' were in the firing line, as he issued a range of new tests that reconfigured services would have to pass.

New services must have support from commissioning GPs, be evidence-based, and strengthen patient engagement and choice. These must be front of mind for any new service being proposed within the NHS.

For pharmacy, it is clear that there is a valued role to play in providing quality patient services in the community. As ever with a change of government, there remain questions on the crucial detail of policy. How will commissioning groups work in practice, and how can pharmacy best partner with these new bodies? What will the new health bill mean for the pharmaceutical needs assessment and quality accounts, both of which would have major impacts on the sector?

The health white paper published this week (see p4-5 and p12 for details), and public health white paper due in the autumn, will both provide opportunities for pharmacy to demonstrate how it can continue to play a central role in the NHS.

Aside from this, of course, is the issue of how long the coalition lasts. Leading figures from both governing parties are unsurprisingly talking a good game about the partnership lasting the full five years. But behind the scenes, backbenchers arriving on the government benches have been looking quizzically at each other – socially liberal Lib Dems and traditional right wing Conservatives wondering how it is they came to be sitting side by side.

Already there have been small signs of rebellion. Lib Dem MPs openly discussed voting against the emergency budget in protest over the VAT increase, while Conservative backbenchers last week tabled a string of presentation bills proposing right wing policy shifts on Europe and crime.

The first weeks of this government have given us a steer of what to expect, but a number of questions remain.

The health white paper will begin to provide some of those answers, but for the NHS – and those involved in and alongside it – a long summer of briefing, positioning and reconfiguring lies ahead.

Chris West is an associate director of political consultancy Insight Public Affairs

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on government policy

REFLECT	How could new government policies affect my pharmacy?
PLAN	Read the coalition's programme for government and its health white paper
ACT	Identify policy changes that will affect my pharmacy and service development opportunities
EVALUATE	Am I prepared for policy changes?

More coalition policies affecting pharmacies:

1. Consumer rights

Consumer rights are given a small leg up in a short section of the coalition's "programme for government". Of the nine elements detailed, the ones that might cause comment from businesses concern new powers to define and ban excessive interest rates on credit and store cards; a seven-day cooling off period for store cards; a move to force credit card companies to provide information in a standard electronic format so customers can see if they are getting a good deal; and stronger consumer protections and – interestingly – measures to enhance customer service in both the private and public sectors.

2. Business

From enterprise policies, which are high on the agenda, business should expect to benefit from the original Lib Dem policy of 'one in, one out' rule for law and regulations, where burdens are reduced or kept level, and the introduction of 'sunset' clauses where laws and regulations die after a given period of time. At the same time, inspections from the authorities will become targeted based on risk. British business will be pleased to know that the coalition is going to work towards making small business rate relief automatic while also lowering the corporation tax rate by simplifying reliefs and allowances.

3. Employment law

Not unsurprisingly, employers face serious employee management burdens. The coalition promises to review employment legislation so that regulation overall remains fair while giving all flexibility. The national minimum wage (NMW) is supported by the coalition, so employers can expect labour costs to rise over time as the NMW rises with each new Low Pay Commission annual report. The coalition is proposing that people stay in work longer; taking changing demographics, and the state of the economy into account, it's an unfortunate necessity. To do this it plans to remove the default retirement age, set the earliest a person can receive a state pension at age 66, and remove the compulsory annuitisation of a pension at age 75. It also plans to change the rules surrounding occupational pensions to make them more attractive.

Despite the recent passing by the last government of the Equalities Act, the coalition will make extensions to the rules on equality at work including: new rules promoting equal pay; the right for all employees to request flexible working; and new measures to end discrimination at work.

Those who have been unemployed, and who wish to start up their own business, will be able to seek help from a new programme called Work for Yourself. The programme would offer access to mentors and start-up finance. New proposals will make the receipt of benefits – unemployment or incapacity - conditional on a willingness to work. At the same time, the benefit system will be altered to incentivise people to work.

4. Tax

Unfortunately, rises in taxation are a key part of deficit reduction. However, it's not all bad news. The coalition proposes to increase the income tax personal allowance, eventually, up to £10,000 per annum, the goal being to help lower and middle-income earners. This will, though, be funded by an increase in the national insurance thresholds and an increase in capital gains tax (CGT) rates for non-business assets by making the CGT rate close to, or the same as, the individual's normal rate of personal taxation. The coalition also wants to remove the 50p tax rate as soon as possible, which could be sooner rather than later if that rate doesn't bring in much revenue. Sadly, for those about to inherit a pile, the inheritance tax threshold is not going to be raised. Those who travel by air will see travel taxed by the plane rather than by the person. A greater proportion of taxation is to be raised by environmental taxes and, as with the previous Labour government, further efforts to deal with tax avoidance will be made.

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CAREERS

7 steps to making a good impression

Whether talking to your boss or your customers, theatre expert Ron Aldridge tells **Hannah Flynn** how to make that first impression count

1. Make a good first impression

'People are making conscious and unconscious decisions on all the information they are taking in," says theatre director Ron Aldridge, "from your breathing and your face to your overall body language. This is because humans are expert at reading each other."

First impressions are crucial to pharmacists, he says, as your customers will be deciding whether or not they want to come back – and people make up their minds within the first 45 seconds of meeting you.

2. Improve your presence

'You can't say, 'I have presence and charisma'; those are not god-given gifts," Mr Aldridge says. "They are skills other people say you have and can be worked on and improved."

Mr Aldridge explains that the way you feel and the way your customer feels are crucial to bear in mind when trying to improve the way you present yourself.

Firstly, you must be aware that the way you are feeling will come across in the way you are speaking, he says.

Secondly, people don't remember what you say for long, but they do remember the way they felt when you spoke to them.

3. Breathe properly

Most people do not breathe properly, says Mr Aldridge, but they can learn how. He suggests a quick exercise that can develop people's breathing and takes only one minute a day.

He explains: "Breathe in, and if your chest comes up you are doing it wrong. So, sit down and breathe in and feel your stomach move out. You can do this in front of the TV, in a meeting or in the car.

"Then you need to count from one, as far as you can on one breath. Most people can get to 20 or 30 at first.

"If you try counting on one breath every day you should eventually be able to count to 60. Once you can do this, you are breathing properly," he says.

4. Deal with tension – and your hands

"The first thing people do when they are feeling tense is clench their shoulders," says Mr Aldridge, "but that is very noticeable. I suggest people clench their buttocks and thighs – this is known as the singer's clench."

Mr Aldridge adds that people are often unsure of what to do with their hands when they are speaking to someone.

He asks: "When was the last time you got up in the morning and said to yourself, 'What shall I do with my hands today?'."

If this bothers you, he suggests placing your hands on top of each other and bring them to your chest as this makes you appear more open to being approached.

5. Explain yourself

Mr Aldridge says: "Professional actors practice until they can't get it wrong, and pharmacists know their subject well, so you can't get an explanation wrong. Pharmacists should work on that assumption."

He recommends thinking about the clearest way you can explain something to a person before saying it. As you speak to more and more people, it should get easier.

6. Learn to speak in the major key

Listen to news readers as they are very good at this, advises Mr Aldridge. People listen to what they have to say as they are speaking 'positively'.

He says pharmacists must make sure they keep channels of communication open, and one of the best ways to do this is to focus on how you finish speaking at the end of a line.

He explains: "Don't lose energy at the end of a sentence, go up to keep it positive. This will make people feel more comfortable as they know where they are with you."

7. Keep an open face

Finally, Mr Aldridge says, pharmacists must ensure they keep an open face when they are approaching people.

"An open face means not letting your eyebrows fall," he explains. "I don't mean walking around with your eyebrows raised to the sky, but keep a relaxed facial expression.

"This is used a lot by comedians but it can be used in all kinds of ways." Using an open face will show you are offering help, Mr Aldridge says.

Theatre director Ron Aldridge was speaking at the annual CAMRx convention in Windsor earlier this month.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on personal presentation

REFLECT	How confident am I about the way I present myself in my pharmacy?
PLAN	Consider how better personal presentation could boost customer confidence and loyalty.
ACT	Use the tips in this guide to improve my presentation.
EVALUATE	Am I more confident approaching and talking to customers and have their reactions and loyalty improved?

Your questions answered

Q I have recently qualified as a pharmacist. What career paths and progressions are open to me in community practice and how should I go about climbing the career ladder?

Lloydspharmacy HR business partner Becky Laycock (pictured) responds:

A The profession is experiencing unprecedented progress and development, and the skills of pharmacists have never been greater in demand. With millions of visits a day, pharmacists are at the forefront of the public's health and wellbeing.

When you first qualify as a pharmacist there's a lot to get used to. Whether your role is in community or hospital pharmacy, you will start to understand the elements of your role that most appeal to you. The opportunities available will largely be dependent on the type and size of organisation. In general, if your future lies in a clinically focused role, there are lots of opportunities within organisations to work within a support function, as a trainer, as a superintendent pharmacist, roles that are focused on external relationships with business-to-business customers and many others, utilising your clinical skills and professional expertise. Gone are the days of a pharmacist hidden behind the counter counting tablets.

If you want to progress to a senior or general management role, you can work your way up the ladder in a larger organisation.

For either route you should speak to your line manager and/or your HR department about opportunities that are available and what skills and experience are required to fulfil your preferred career path. Create a plan that sets out how you intend to develop this experience and skills, which should include the roles you could move to in order to gain the appropriate skills and experience.

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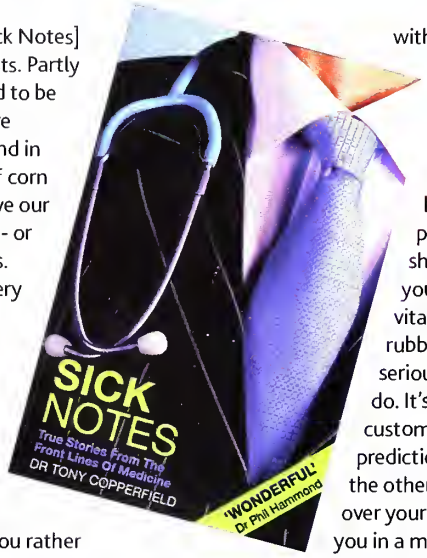
Postscript...

Pharmacists and GPs: pen pals?

A few weeks back, C+D asked you to pen your responses to infamous GP columnist Dr Tony Copperfield, who had a few choice words to say about pharmacists. The responses were excellent. If fact, some were so good, we thought we'd share them...

Dr Copperfield's original letter to C+D



Despite what my book [Sick Notes] says, I quite like pharmacists. Partly because we're all supposed to be part of one big primary care family, running hand in hand in soft focus through fields of corn in a concerted effort to save our patients from viral-, pollen- or emotional-induced sniffles. But also because you do very occasionally bale me out ('Dr Copperfield, can I just check you really did want to prescribe some potentially bone-marrow-toxic chloramphenicol capsules for this child's conjunctivitis? Or would you rather I dispense the ointment?') And you do it without laughing at me.

You know there's a but coming, though. And it's this. But I do wonder whether you've ever resolved that tension between being a health professional and being a shopkeeper. Because while your shelves are filled with vitamins, tonics and herbal rubbish, I find it hard to take seriously all the good work you do. It's as though you're doing a customer's cardiovascular risk prediction on the one hand and, on the other, telling him his fortune. Get over your identity crisis and I'll view you in a much more sympathetic light. Though I'll have far less to write about.

Readers respond

Dear Dr Copperfield
I'd love to get past my identity crisis of selling vases with silk flowers and photo frames. I'd love to concentrate on developing and providing professional services that are recognised and appreciated by our fellow healthcare colleagues. I'd love to be able to fully devote my time to ensuring I don't miss the need to 'bale out' one of my prescribers.

However, the problem is that unlike our medical colleagues 1) we can't force people to take up our services by withholding treatment until they attend; 2) we can't demand funding to provide these services or threaten to withdraw them; 3) we don't have the luxury of having a 'list' of patients who come exclusively to us for whom we get income if they turn up or not; and 4) the government and their elected bodies tell us they want us to develop these roles but won't pay us. Instead they allow manufacturers to restrict supply of medicines through selected wholesalers who then impose a discount on us that is less than the amount the government claws back. And they reduce our opportunity to benefit from being a good 'businessman' by reducing purchase profit.

So, instead of criticising us for trying to make a better living for ourselves in any way that can't be taken away/reduced by the powers that be, support us with these bodies. Allow us to take over some of the mundane roles that your skills don't need to be used for, allowing you to focus on the patients who really need you. And in doing so, support us in that we need to be adequately reimbursed for us to develop professional services that you guys will recognise as such and value.

> **"Stop your hypocrisy, Dr C, and I'll give you back some of the respect I used to have for GPs"**
>
> PETER HOPLEY
> BREWERY LANE PHARMACY

Perhaps then we can run through our field of corn, if not hand-in-hand at least side by side. And just ask us for some stories about our customers wanting to order their 'ferocious sulphate' tablets and we'll give you plenty to write about!
Gareth Rowe, Nantymoel Pharmacy, Bridgend

Gareth wins a copy of Dr Copperfield's latest book, Sick Notes.

Dear Dr Copperfield
Are you a not-for-profit salaried GP? Or are you, like me, owner of a business that has the NHS as a customer?

Stop your hypocrisy, Dr C, and I'll give you back some of the respect I used to have for GPs.

PS The latest news from the dispensing doctors in their posh health centre near me is that they have appointed a 'business development manager'. Will Dr C's practice be doing the same soon?
Peter Hopley, Brewery Lane Pharmacy, Newcastle upon Tyne

Just a message to Dr Copperfield
The doctor should be thankful his book is not handwritten, since pharmacists would be the only people who would be able to read it!
Shelley Chapman, Co-operative Pharmacy, Salford

To the purely altruistic Dr Copperfield
Yes, you are right. In the past there may have well been some conflict between our professional role and the need to make money. Now, of course, that we have the respect of colleagues and are paid sensible rates for the services that we perform, we can make a reasonable living and provide them in a professional manner working in collaboration with other health professionals. Oh, and if I hadn't had to make an appointment to get you to alter these prescriptions...

Dr Copperfield merely shrugs and writes "delusional" on the sick note he has in front of him. The meeting is over.
Martin Fisher, Freefield Pharmacy, Lerwick

Would you like to see a regular column by Dr Copperfield?
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Where is the pharmacy industry going?

Tricky question. Simple answer.

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Pictured L to R: Bernard Mweseka, Pharmacy Manager, Day Lewis, Dvyesh Patel, Pharmacy Technician, MED-Chem Pharmacy; James Davies, Academic Pharmacist, London School of Pharmacy; Mike Ritson, Superintendent, ABC Drugstores; Richard Harrild, Retail Sales Manager, Lloydspharmacy; Raj Bali, Pharmacist, Lloydspharmacy; Ali Gul Ozbek, Owner-Superintendent, MED-Chem Pharmacy.

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Cardiovascular prevention: Reduction of cardiovascular mortality and morbidity in patients with manifest atherosclerotic cardiovascular disease or diabetes mellitus, with either normal or increased cholesterol levels as an adjunct to correction of other risk factors and other cardioprotective therapy. **Posology and Method of Administration:** *Adults:* The dosage range is 5 - 80mg/day depending on condition given orally as a single dose in the evening. Adjustments of dosage if required should be made at intervals of not less than 4 weeks to a maximum of 80mg/day given as a single dose in the evening. The 80mg dose is only recommended in patients with severe hypercholesterolaemia and high risk for cardiovascular complications. No modification of dosage should be necessary in patients with moderate renal insufficiency. In patients with severe renal insufficiency dosages above 10mg/day should be carefully considered. *Children:* (10 - 17 years of age, boys Tanner Stage II and above and girls who are at least one year post-menarche) with heterozygous familial hypercholesterolaemia, starting dose is 10mg once a day in the evening. The recommended dosing range is 10 - 40mg/day. Adjustments should be made at intervals of 4 weeks or more. Limited experience of simvastatin in pre-pubertal children is limited. *Elderly:* No dosage adjustment is necessary. **Contra-indications:** Hypersensitivity to simvastatin or to any of the excipients. Active liver disease or unexplained persistent elevations of serum transaminases. Pregnancy and lactation. Concomitant administration of potent CYP3A4 inhibitors. **Precautions:** Myopathy/rhabdomyolysis. Hepatic effects: persistent increases (to > 3 x ULN) in serum transaminases have occurred in a few adult patients who received simvastatin. When simvastatin was interrupted or discontinued in these patients, the transaminase levels usually fell slowly to pre-treatment levels. The product should be used with caution in patients who consume substantial quantities of alcohol. Interstitial lung disease: exceptional cases of interstitial lung disease have been reported with some statins, especially with long-term therapy. Excipients: Warnings: parahydroxybenzoates which may cause allergic reactions. **Interactions:** The risk of myopathy including rhabdomyolysis is increased during concomitant administration with fibrates. There is a pharmacokinetic interaction with gemfibrozil resulting in increased simvastatin plasma levels. Rare cases of myopathy/rhabdomyolysis have been associated with simvastatin co-administered with lipid modifying doses (≥1g/day) of niacin. Drug interactions associated with increased risk of myopathy/rhabdomyolysis. Potent CYP3A4 inhibitors: Contraindicated with simvastatin: Gemfibrozil. Avoid but if necessary, do not exceed 10mg simvastatin daily: Ciclosporin, danazol, other fibrates (except fenofibrate). Do not exceed 10mg simvastatin daily: Amiodarone, verapamil. Do not exceed 20mg simvastatin daily: Diltiazem. Do not exceed 40mg simvastatin daily: Fusidic acid. Patients should be co-monitored: Grapefruit juice. Avoid grapefruit juice when taking simvastatin. Effects of other medicinal products on simvastatin: Combination with itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone is contraindicated. Caution: the dose of simvastatin should not exceed 10mg daily. Very rare cases of elevated INR have been reported. **Pregnancy and Lactation:** Simvastatin Oral Suspension is contraindicated during pregnancy and lactation. It is not known whether simvastatin or its metabolites are excreted in human milk. Women taking simvastatin Oral Suspension should not breast-feed their infants. **Effects on Ability to Drive and Use Machines:** Simvastatin Oral Suspension has no or negligible influence on the ability to drive and use machines. **Undesirable Effects:** Investigations: Rare: increases in serum transaminases, elevated alkaline phosphatase, increase in serum CK levels. Blood and lymphatic system disorders: Rare: anaemia. Nervous system disorders: Rare: headache, paraesthesia, dizziness, peripheral neuropathy. Very rare: memory impairment. Gastrointestinal disorders: Rare: constipation, abdominal pain, flatulence, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis. Skin and subcutaneous tissue disorders: Rare: rash, pruritus, alopecia. Musculoskeletal, connective tissue and bone disorders: Rare: myopathy, rhabdomyolysis, myalgia, muscle cramps. General disorders and administration site conditions: Rare: asthenia. Hepato-biliary disorders: Rare: hepatitis/jaundice. Very rare: hepatic failure. Psychiatric disorders: Very rare: insomnia. **Overdose:** There is no specific treatment in the event of overdose. **Shelf Life and Storage:** 12 months unopened, 1 month opened. Do not store above 25°C. **Legal Category:** POM. **Pack Size and NHS Price:** 20mg/5ml, 150ml - £99.50. 40mg/5ml, 150ml - £152.00. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE, UK. **Marketing Authorisation Number:** 20mg/5ml PL 00427/0146, 40mg/5ml PL 00427/0147. **Date of Preparation:** May 2010

References: 1. Benner JS, Glynn RJ, Mogun H, Long-term persistence in use of statin therapy in elderly patients. *JAMA* 2002; **288**: 455-61 2. Crouch M. *Am Fam Physician* 2001; **63**: 309-20, 323.

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Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.